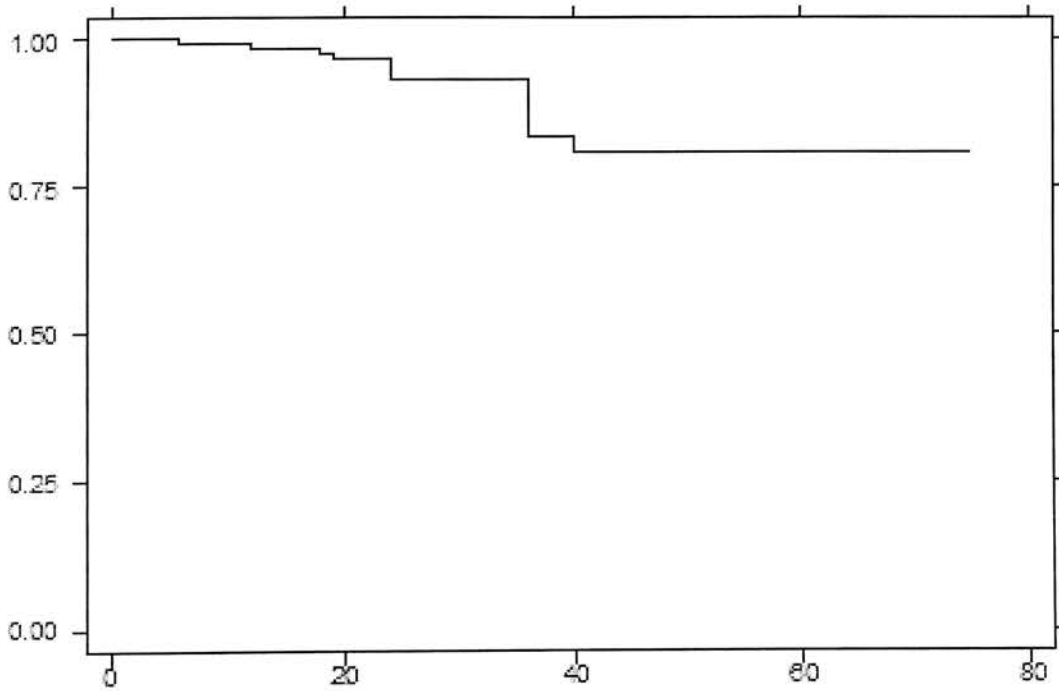


Comparative (anatomical) results for maximal level of prolapse

	Pre-operative	1 month	Long term
Stade 0	0	80 (63%)	28 (26%)
Stade 1	0	37 (29%)	42 (39%)
Stade 2	2 (1%)	9 (7%)	26 (24%)
Stade 3	66 (50%)	1 (1%)	11 (10%)
Stade 4	63 (49%)	0	1 (1%)

Prolapse recidive curve

Conclusion. Laparoscopic promontofixation provided good long term support of the pelvic floor in 89%. Our experience confirms the tremendous potential of laparoscopic surgery for the treatment of all aspects of pelvic floor disorders by the same

route. Stress incontinence, cystocele, hysterocele, rectocele, or enterocele can be treated effectively and safely. However, the operative time is longer than with the open route, and the surgeon must be highly experienced.

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THE ROLE OF CTD IN GENITAL PROLAPSE GENESIS

Background: now the role of connective tissue displasia (CTD) in genesis of genital prolapse is known. Genital prolaps as nondifferentiated kind of CTD is a manifestation of generalized CTD on the level of reproductive system which develops in young unipara women after noncomplicated delivery without hormonal disorders and factors provided intraabdominal pressure increasing.

Materials and methods. First of all connective tissue defects are connected with altered synthesis of collagen. The immunohistochemical investigation of intraoperative samples: vessels and surrounding tissues,

pelvic fascia and ligaments was performed in patient with CTD to evaluate the morphological structure and quality of collagen content.

Results. 61,9% of 21 patients with CTD did not have macroscopic changes of examined tissues. The I and III types of collagen were expressed in all patients with CTD but both collagens had atypical structure and did not form fiber funiculus. Instead of I and III types of collagen a lot of IV type of collagen was expressed that realized in decreasing of elasticity of ligamental apparatus.

Clinical and constitutional signs of CTD were re-

vealed in 104 (24,1%) from 432 examined patients with different forms of urine incontinence which combined with anatomical disposition of pelvic organs at 81,5% of cases. These patients more often showed CTD markers.

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An urogenital fistulas are serious complication after heavy multiple traumas, wounds, and radical operations. We offer a method of conservative treatment of the given pathology with the help of cultures of allogenic cells.

The purpose of research: to estimate the first experience and opportunity of allogenic skin's cells application for a treatment of genital fistulas.

Object and methods. We carry out the treatment of 12 patients in the age from 38 till 56 years (on the average – 44 years) with genital fistulas, existed from 3 to 12 months. 9 patients had bladder-vaginal fistulas, and 3 had rectovaginal fistulas (one patient had three fistulas simultaneously). The diameter of fistulas was from 1 up to 4 mm. The causes of all fistulas were posttraumatic due to complications during operations. All patients received antibiotics and antiinflammatory therapy before the manipulation. 4 patients were unsuccessfully operated for treatment of fistulas before the transplantation of allogenic skin's cells. In our clinical research there

Conclusion. Instead of known criteria of CTD expression we offer to use the list of the most significant signs. The combination of three or more of them testifies about nondifferentiated CTD.

AN APPLICATION OF ALLOGENIC SKIN'S CELLS FOR A TREATMENT OF GENITAL FISTULAS

were used fibroblasts and keratinocytes, which were grown up on microcarriers.

Results of research. Received data show that straight fistulas were closed for 5-7 days after application of cells (n = 5). In opposite, straight fistulas had recurrent and required the second transplantation due to the healing had come on 12th-14th days. Three-multiple transplantation was executed at 4 patients. Thus the closing of a fistula had come only at one patient. The preservation of fistulas was ascertained at three patients: in two cases the fistulas were bladder-vaginal and in one – rectovaginal. It was marked, that in two inefficient cases straight linear bladder-vaginal fistulas took place and their initial diameters was about 4 mm. In a case of unsuccessful treatment of rectovaginal fistula we had met three fistulas: two invaded into vagina and one – in perineum area between back soldering and anal sphincter.

Conclusion. Thus, the first experience of using of allogenic cells of skin in treatment of genital fistulas allows to continue the development of the given alternative method and its introduction in medical practice.

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THE EFFECTIVENESS OF SLING USING IN TREATING OF STRESS INCONTINENCE IN WOMEN. THE RESULTS OF 28 OPERATIONS

The aim. Analysis of effectiveness in use of sling in incontinence treating in women.

Material and methods. The department of urology in Rostov State Medical University has the experience in using of sling in 28 (100%) patients from 40 to 63 years old. Previously 20 (71,4%) patients had complicated deliveries. 16 (57,1%) pts had perineal tears during deliveries, 3 (10,7%) pts had delivered large babies. And 1 (3,6%) patient had the late termination of pregnancy. Duration of disease in 6 (21,4%) pts was from 1 to 3 years, in 12 (42,8%) – from 1 to 3 years from 4 to 7 years, in 10 (35,7%) – more than 10 yrs. Previously 22 (78,6%) pts were treated conservatively without effect. According to classification of Mc.Guirr 6 (21,4%) pts had 2a type incontinence, 18 (64,3%) had 2b type incontinence, 3 (10,7%) pts had 3a type. 17 (60,7%) pts had cystocele. And 3 (10,7%) had rectocele.

Operation. In anterior wall of vagina there were

placed two semicircular sutures with prolene formed the circumference of 5cm diameter. Leaving 5mm from the line of suture we cut the wall of vagina, lateral sides of wound was mobilized on 2.5cm from each side. Leaving the urethra on right and left side we made canals to retropubic area. Needle-perforator one by one was led through the canal from two incisions made above to the both sides of pubis and was taken out through the vaginal wound. With the help of perforator suture was placed in the canal in retropubic area. To confirm that no perforation of bladder was made the ureterocystoscopy was done. If it was needed the plastics of cystocele was made with the help of pubocervical ligaments and posterior wall of bladder. Lateral layer of vaginal wound was ligated by vicryl N-3-0. Thus we inserted the remaining layer of the wound into itself. The sutures were together by making an additional cut at the center and through which they were inserted